

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

15461

State File No.

 BIRTH NO. **FILED APR 18 1953** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3516**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 2257	
b. CITY OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		e. STREET ADDRESS (If rural, give location) 25 Mug Hotel, 819 1/2 Market St.	
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) GILBERT c. (Last) BEGAL	4. DATE OF DEATH (Month) (Day) (Year) MARCH 27, 1953		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 3	8. DATE OF BIRTH 4-18-01
9. AGE (In years last birthday) 51	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Randolph Co. Arkansas.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME William Begal	
13b. MOTHER'S MAIDEN NAME Mary Acree		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Martin Begal, Physician, Hch.		ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary tuberculosis INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3-25-53 , 19__, to 3-27-53 , 19__, that I last saw the deceased alive on 3-27-53 , 19__, and that death occurred at 3:20 AM m., from the causes and on the date stated above.			
23a. SIGNATURE Jim Higgins, MD (Degree or title)		23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 3-27-53
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3-27-53	24c. NAME OF CEMETERY OR CREMATORY Harmony	24d. LOCATION (City, town, or county) (State) Pocahontas, Ark. Rt. #2
DATE REC'D BY LOCAL REG. APR 2 1953		25. FUNERAL DIRECTOR'S SIGNATURE M.C. McNabb, Pocahontas, Ark. ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *James R. Chapman*.....

Licensed Embalmer No. *455*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.